PATIENT
Mr. _______________ Date _______________
Mrs.
Miss _______________ Birthdate _______________ Age _______________ Soc. Sec. No. _______________

Home Address _______________ City _______________ Zip _______________ Phone No. _______________

Person Financially Responsible _______________ Relationship to you _______________ Business Phone _______________ _______________

Primary Insurance _______________ Subscriber name _______________ Birthdate _______ SS# _______________

Group & Plan Number _______________ Employer _______________ Phone No. _______________

Secondary Insurance _______________ Subscriber name _______________ Birthdate _______ SS# _______________

Group & Plan Number _______________ Employer _______________ Phone No. _______________

Referred to our office by: _______________ When was your last dental exam? _______________

When was your last cleaning? _______________

Medical History

Physician _______________ Phone No. _______________

Are you taking any medication, pills or drugs? _______ If so, please list _______________

1. Are you having pain or discomfort at this time? .... ☐ YES ☐ NO
2. Do you feel very nervous about having dental treatment? .... ☐ YES ☐ NO
3. Have you ever had a bad experience in the dental office? .... ☐ YES ☐ NO
4. Have you been a patient in the hospital during the past two years? .... ☐ YES ☐ NO
5. Have you been under the care of a medical doctor during the past two years? .... ☐ YES ☐ NO
6. Have you taken osteoporosis drugs? (i.e. Fosamax, Boniva, Reclast, Actonel).......... ☐ YES ☐ NO
7. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by sulfa, penicillin, aspirin, codeine, or any drugs or medications? .... ☐ YES ☐ NO
8. Have you ever had any excessive bleeding requiring special treatment? .... ☐ YES ☐ NO
9. Check any of the following which you have had or have at present:

☐ Heart Failure	☐ Stroke	☐ Chemotherapy (Cancer, Leukemia)	☐ Drug Addiction
☐ Heart Disease or Attack	☐ Kidney Trouble		☐ Hemophilia
☐ Angina Pectoris	☐ Ulcers	☐ Arthritis	☐ Venereal Disease (Syphilis Gonorrhea)
☐ High Blood Pressure	☐ Emphysema	☐ Rheumatism	☐ Cold Sores
☐ Heart Murmur	☐ Cough	☐ Cortisone Medicine	☐ Genital Herpes
☐ Rheumatic Fever	☐ Tuberculosis (TB)	☐ Glaucoma	☐ Epilepsy or Seizures
☐ Congenital Heart Lesions	☐ Asthma	☐ Pain in Jaw Joints	☐ Fainting or Dizzy Spells
☐ Scarlet Fever	☐ Sleep Apnea	☐ AIDS or HIV	☐ Latex Allergy
☐ Artificial Heart Valve	☐ Sinus Trouble	☐ Hepatitis	☐ Psychiatric Treatment
☐ Heart Pacemaker	☐ Allergies or Hives	☐ Alcoholism	☐ Bruise Easily
☐ Artificial Joint	☐ Thyroid Disease	☐ Yellow Jaundice	☐ Diabetes
☐ Anemia	☐ X-ray or Radiation Treatment	☐ Blood Transfusion	☐ Sulfite Allergy
☐ Life Style Drugs			☐ Implants

10. Have you lost or gained more than 10 pounds in the past year? .... ☐ YES ☐ NO
11. Do you ever wake up from sleep short of breath? .... ☐ YES ☐ NO
12. Are you on a special diet? .... ☐ YES ☐ NO
13. Has your medical doctor ever said you have a cancer or tumor? .... ☐ YES ☐ NO
14. Do you have any disease, condition, or problem not listed? .... ☐ YES ☐ NO
15. WOMEN: Are you pregnant now? .... ☐ YES ☐ NO
    Are you practicing birth control? .... ☐ YES ☐ NO
    Do you anticipate becoming pregnant? .... ☐ YES ☐ NO
16. Relative whom we can contact in event of emergency (*not living at same household*)

Name _______________ (Last) _______________ (First) _______________ (Middle) Phone _______________

Address _______________ (Number and Street) _______________ (City) _______________ (State) _______________ (Zip)

I understand that my insurance is an agreement beteween my insurance company and me. I also understand that I am responsible for the balance of my dental account regardless of my insurance.

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

_______________ Date

_______________ Signature of Patient, Parent or Guardian